

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**FAMILY CENTERED TREATMENT**

**Effective: 1/1/2015**

**Revised 12/2/2014**

**I. Services Description**

Family Centered Treatment® (FCT) was developed as a model of treatment designed for use in the provision of intensive in home services. FCT is owned by Family Centered Treatment Foundation Inc. (FCTF); a nonprofit corporation devoted to furthering the effectiveness of family preservation services. FCT origins derive from practitioners' efforts to find simple, practical, and common sense solutions for families faced with forced removal of their children from the home due to their delinquent behavior or dissolution of the family due to both external and internal stressors and circumstances. This service shall be for the entire family, culturally competent, and shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need and congruent with the DCS case plan.

FCTF is the owner of the evidenced-based family preservation treatment model FCT, and the related training program, Wheels of Change©. FCTF licenses provider agencies that meet the stringent criteria necessary to provide Family Centered Treatment. A readiness assessment is implemented by FCTF to determine if the applicant agency meets the criteria. When agencies procure licensure as a provider of FCT, FCTF provides the Wheels of Change online and field based competency training program, supervisor certification and training process, fidelity oversight of the implementation of FCT, and ongoing fidelity & program evaluation related to FCT. Upon written agreement by an organization and FCTF to provide FCT, the provisional status of the organization or sites will commence. For additional information regarding FCT, Wheels of Change, and the process to become a provider, follow the link:

<http://familycenteredtreatment.com/>

The service must aim at improving long term outcomes for children and their families by providing services that are effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional and educational well-being through family value changes. Additionally, the FCT Service provider must monitor and address any safety concerns for the child(ren). FCT service providers must adhere to State and Federal laws requiring the reporting of suspected abuse and neglect. The intervention must be strength-based with the family participating in identifying the focus of services.

Additionally, the provider must provide intensive safety planning and crisis response services 24hours a day/7 days per week/365 days a year.

The provider must advise the referent within 24 hours of receipt of the referral as to whether or not the provider has the capacity to serve the family. There will be at a minimum of two face to

face contacts per week with the family by the provider clinician commencing within 48 hours of the referral.

There will be 185 hours of service during the six months of service provision consisting of 80 percent direct face-to-face service between clinician and the family and 20 percent indirect service.

Direct service (minimum 80%) includes:

- Family specific face to face contacts with the identified family during which services are defined in the applicable service standard are performed. Members of the client family are to be defined in consultation with the family and approved by the DCS office. This may include persons not legally defined as part of the family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by DCS for the purpose of goal driven communication regarding the services being provided to the family
- Includes in-vehicle (or in transport) time with client provided it is identified as goal directed, face-to-face, and approved/specified as part of the family's intervention plan
- Includes crisis intervention and other goal-directed interventions via telephone with the identified family
- Includes time spent completing any DCS approved standardized tool to assess family functioning
- Supervised visitation is included in the minimum direct service hours if it includes a therapeutic component and/or modeling and coaching the parent to improve parenting skills

Indirect service (maximum 20%) includes:

- Routine report writing
- Travel time
- Court attendance when requested
- Crisis intervention and other goal directed interventions via telephone with the identified client/family
- Comprehensive case management including stakeholder/referral/collateral contact. Contact with referring/community stakeholders or collaterals for the purpose of case coordination, updating, planning, case staffing, child and family team meetings, court, or other information shared for the advancement and benefit of the family to complete the identified service plan goals
- Clinical service/treatment planning/case assessment. Examples of allowable components include development of clinical service components necessary for provision of services, service treatment plan development, clinical case assessment and planning, necessary case coordination documentation as required by DCS, other specific assessment tools as defined by DCS, review of video session if required by the EBP model, discharge planning/documentation
- Supervision – time allotted for supervision is dedicated to case staffing/assessment/planning specific to the client/family

## **II. Trauma Specific Interventions: (modified from the SAMHSA definition) Trauma Informed Care**

Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

### **Trauma Specific Interventions: (modified from the SAMHSA definition)**

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

## **III. Inclusive Service Model**

The service shall be all inclusive to meet the needs of the family. There should not be a need for DCS to contract/refer the child(ren) or family for additional services as the service provided shall be all inclusive to meet the needs of the family. The service includes but is not limited to assessment of service need, home based therapeutic services, home based casework services, homemaker services, visitation supervision, parent engagement services, parent education, transportation assistance.

Examples of services that may be outside of the services provided under this Service Standard include: Diagnostic and Evaluation Services (Clinical Interview and Assessment, Psychological Testing, Neuropsychological Testing, Psychiatric Services), Residential Substance Use Treatment services, Detoxification Services and other medical services, Substance Use Disorder Outpatient Treatment.

To avoid confusion regarding services payable in addition to the Family Centered Services per diem, Provider must actively communicate with the assigned DCS family case manager to determine which services are appropriate for the family and are consistent with model or practice

in place. Provider must then confirm cancellation of extraneous services and confirm documentation of any DCS supervisor-approved additional services to be paid outside the per diem.

#### **IV. Quality Service Reviews**

In order to ensure providers are offering services in accordance with the DCS practice model, providers should be trained in the Quality Service Review process and participate in the regional Quality Service Reviews. This information will be valuable to your agency in understanding the Practice Model and quality standards in which the system is measured. Understanding quality expectations will assist your agency in planning and implementing services.

The Comprehensive Home-based Service Standard requires only that one person from each agency participate in the QSR as a shadow for each region they serve. If your agency is interested in completing the entire training process that is permitted, but is not required.

The agency will need to select one individual from within the agency to participate in the QSR. That person will need to attend a 2 day training on the QSR Protocol and process. Following training, providers will be required to attend QSR in the regions in which they provide services through the comprehensive contract. Providers will participate in the QSR as a shadow reviewer. Each QSR is scheduled for two consecutive days, beginning at 8am and ending no later than 8pm. An agency will need to select a minimum of one representative to participate in the QSR in each region they provide comprehensive services in. This could be the same person for all regions or a different person for each region. Each person participating in the QSR must first complete the two day training.

Providers will not be penalized if the available reviewer positions are full. The provider should simply wait for the next QSR round for the Region. The agency needs to shadow in each region that they provide services

After shadowing the QSR process, individuals would be able to complete the process of becoming a Qualified Mentor. This process would include the 2 day training, the shadow, 2 lead experiences, a 2 hour webinar on how to be a mentor and then the individual would mentor a mentor. At that point the person would be qualified. However, this is not necessary. The Service Standard requires only that the individual shadow in each region that service is provided.

The cost of participation in the QSR is included in the comprehensive service rate.

#### **V. Target Population**

All clients served must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with CHINS status.
- 2) Children which have status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families (as defined by the family) with whom they are placed.

#### **VI. Goals and Outcomes**

**Goal #1** Maintain timely intervention with the family, regular timely communication with

referring worker (a minimum of bi-weekly).

**Objectives:**

1) Staff is available for consultation to the family 24-7 by phone or in person.

**Fidelity Measures:**

1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.

2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.

3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

**Goal #2** Clients will achieve improved family functioning and demonstrate value changes.

**Objectives:**

1) Goal setting, and service planning are mutually established with the client and Direct Worker within 30 days of the initial face-to-face intake and a written report signed by the Direct Worker and the client is submitted to the current FCM/Probation Officer.

**Client Outcome Measures:** 1) 65% of the families that have a child in residential care prior to the initiation of service will be reunited within four to six weeks of the service referral.

2) 95% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)

3) 70% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

4) 65% of the children/youth involved with an open JD/JS case will have no occurrences of reoffending throughout the service provision period.

5) 60% of those individuals/families with a successful case closure will not have a further incident of abuse or neglect at 12 months post discharge.

6) 60% of those children/youth with a successful case closure will not have any occurrences of reoffending at 12 months post discharge.

**Goal #3** DCS/Probation and clients will report satisfaction with services.

**Outcome Measures:**

1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report conducted via survey monkey.

2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed and offered to all clients by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients.

**VII. Minimum Qualifications**

Department of Child Services  
Regional Document for Child Welfare Services  
Term 2/1/2013-6/30/15  
December 2, 2014

The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete the service as required by state law and the FCT model. At a minimum, the following apply:

**FCT Therapist:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field, and 2 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist, or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Therapist, 3) Mental Health Counselor.

Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

- Knowledge of family of origin/intergenerational issues
- Knowledge of child abuse/neglect
- Knowledge of child and adult development
- Knowledge of community resources
- Ability to work as a team member
- Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
- Belief in the family preservation philosophy
- Knowledge of motivational interviewing
- Skillful in the use of Cognitive Behavioral Therapy
- Skillful in the use of evidence-based strategies

**Supervisor:**

Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Social Worker, Marriage and Family Direct Worker, or Mental Health Counselor Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.

It is the responsibility of the provider to maintain staff with the skills necessary to effect change in the families that will be referred through adherence to the FCT model. This responsibility includes the supervision and training of the staff. There will be one supervisor dedicating 100% of their time supervising no more than nine clinicians (FCT or other clinicians). FCT clinicians will provide services for no more than 5 cases which will account for 100% of their time. Clinicians can carry a mix of FCT and non FCT cases. Each FCT case on the caseload would be the equivalent of 20% of a clinician's time. (Traditional low intensity cases should be considered 8%, Comprehensive Tier 1, 2, and 3 are 20%, Comprehensive Tier 4 and 5 are 12.5%.) Clinician caseloads should not exceed 100%. The intensity of the cases should always

be considered when determining the case load size. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of the FCT model. The provider must have the capacity to hold weekly team meetings for all team members. Supervision may include individual, group, and direct observation modalities and can utilize teleconference technologies.

### **Support Worker:**

Bachelor’s Degree in social work, psychology, sociology, or a directly related field. These staff must be trained in the basic principles of the FCT model and their practice must be coordinated and directed by the direct professional staff. There will be one Support Worker per every three clinicians.

Staff must possess a valid driver’s license.

### **VIII. Reporting**

Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided. These monthly reports are due by the 10th of the month following service. DCS will require an electronic reporting system which will include documenting time and services provided to families. DCS may also adopt a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

### **IX. Billable Unit**

**Per Diem rate:** The per diem will start the day of the first face to face contact after the recommendation for acceptance into this program is approved by DCS. There will be a minimum of 2 multi-hour face-to-face contacts with the family per week during the first two phases of the service. The per diem rate will be all inclusive of the services outlined in Section III above.

#### **Interpretation, Translation and Sign Language Services**

All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client). Sign Language should be done in the language familiar to the family.

These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session. No side comments or conversations between the Interpreters and the clients should occur.

The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate. Certification of the Interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

### **Supervised Visitation**

If the requested/required supervised visitation needs of the referred family, exceed what is reasonable as part of the comprehensive service, the provider can request additional fee for service Supervised Visitation hours to be added. Providers must complete the Comprehensive Visitation Appeal form to request additional supervised visitation billable hours and submit to the local Regions Services Coordinator or Probation Service Consultant for processing. Referrals for additional supervised visitation will be referred for a maximum of 30 days. All additional supervised visitation must be approved by Central Office, not all requests will be approved. DCS has determined that the services that are provided under this service standard are not appropriate to be billed to Medicaid.

## **X. Case Record Documentation**

FCT providers will be required to enter service logs and phase dates into the KidTraks system, including uploading of fidelity documents. Entries should be made within 48 hours of service completion.

Case record documentation for service eligibility must include:

- 1) A completed, and dated DCS/ Probation referral form authorizing services
- 2) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
- 3) Safety issues and Safety Plan Documentation
- 4) Documentation of Termination/Transition/Discharge Plans
- 5) Treatment/Service Plan
  - a. Must incorporate DCS Case Plan Goals and Child Safety goals.
  - b. Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
- 6) Monthly reports are due by the 10<sup>th</sup> of each month following the month of service, case documentation shall show when report is sent.
  - a. Provider recommendations to modify the service/ treatment plan
  - b. Discuss overall progress related to treatment plan goals including specific examples to illustrate progress

- 7) Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
- 8) When applicable Progress/Case notes may also include:
  - a. Service/Treatment plan goal addressed (if applicable-
  - b. Description of Intervention/Activity used towards treatment plan goal
  - c. Progress related to treatment plan goal including demonstration of learned skills
  - d. Barriers: lack of progress related to goals
  - e. Clinical impressions regarding diagnosis and or symptoms (if applicable)
  - f. Collaboration with other professionals
  - g. Consultations/Supervision staffing
  - h. Crisis interventions/emergencies
  - i. Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
  - j. Communication with client, significant others, other professionals, school, foster parents, etc.
  - k. Summary of Child and Family Team Meetings, case conferences, staffing
- 9) Supervision Notes must include:
  - a. Date and time of supervision and individuals present
  - b. Summary of Supervision discussion including presenting issues and guidance given.

## **XI. Service Access**

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by DCS/Probation.

The referral must be accepted within the KidTraks vendor portal within 72 hours. Referral must be accepted within the KidTraks vendor portal within 72 hours. Provider has 24 hours to contact the referral source if unable to accept the referral based upon lack of capacity. The family must be seen face to face, within 48 hours of referral.

DCS will have the option to put the referral on hold or terminate the family's referral at an earlier date due to changes in family status or loss of engagement.

If a child is the only child participating in services and there are no other siblings, and that child is in residential placement, the child must be transitioning to a less restrictive placement within the next 30 days for the referral to be made.

Provider is to contact Family Case Manager after missed appointments. After three unsuccessful face to face contacts, the provider must notify the Family Case Manager and billing must be suspended until successful face to face contact is made. Family Case Manager should be contacted to evaluate the need for early termination of the referral.

Providers must initiate a re-authorization for services to continue beyond the approved period. All comprehensive referrals are created for 1 year and include 185 units. Once the 185 units have been billed, any necessary extensions should be requested through central office.

## **XII Adherence to the DCS Practice Model**

Services must be provided according to the Indiana Practice Model, providers will build trust based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, and planning and intervening to partner with families and the community to achieve better outcomes for children.

### **I. Trauma Informed Care**

Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>): Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

#### **Trauma Specific Interventions: (modified from the SAMHSA definition)**

- The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
- The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

### **XIII. Cultural and Religious Competence.**

Provider must respect the culture of the children and families with which it provides services. All staff persons who come in contact with the family must be aware of and sensitive to the

child's cultural, ethnic, and linguistic differences. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:

<http://www.in.gov/dcs/files/LGBTQPracticeGuidebookFinalforOnlineViewing.pdf>

Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

#### **XIV. Child Safety**

Services must be provided in accordance with the Principles of Child Welfare Services. Please note: All services (even individual services) are provided through the lens of child safety. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.